Redwood School data collection sheet for new starters 2020 - 2021

Surname:		**Legal Surname:**		
Forename:		**Middle name:**		
Chosen name:		**Gender:**		
Date of Birth:		**Year:**		**Reg Group:**
Address:				

PARENT/CARER DETAILS

Please give details of all persons who have parental responsibility and place them in order you wish them to be contacted in an emergency. For persons who have parental responsibility but do not live at the same address as the child, please tick the correspondence box if they require additional copies of school reports etc. **If possible, we need 4 contacts this does not need to be a family member and could be a trusted friend or neighbour**.

Priority	**Parental Responsibility YES or NO**	**Name / Relationship**	**Requires Correspondence YES or NO**	**Home Address / Telephone /Email**	**Work Address/ Phone / Email**
1				Address: Tel: Mobile: Email:	Address: Tel: Mobile: Email:
2				Address: Tel: Mobile: Email:	Address: Tel: Mobile: Email:

3				Address: Tel: Mobile: Email:	Address: Tel: Mobile: Email:
4				Address: Tel: Mobile: Email:	Address: Tel: Mobile: Email:

Outside agencies that are involved with your child

e.g. Social worker, HYM, Physio, OT, SALT, RANS…….

Agencies Name	Contact Name	Telephone	Email Address

Travel Arrangements

Please tick the appropriate choice

	School Bus		Public Bus		Car		Walk		Taxi		Bicycle		Train	Other:

Food Allergies

The top 14 food allergens are listed below. If your child has a confirmed or suspected allergy to one of these ingredients, please tick the relevant box. (Please note this question is asking about allergies, not likes/dislikes)

Milk		Fish	
Eggs		Shell Fish	
Gluten		Molluscs	
Peanuts		Mustard	
Nuts		Celery	
Sesame seeds		Sulphur Dioxide & Sulphites	
Soya Beans			
Other Food Allergies			

Dietary Preferences	**Does your son/daughter have any dietary preferences?** (If yes please see below)			
	Blended Food		Tube Fed	
	Halal only		Vegetarian	
	Nil by mouth		Drink Thickener	
	Soft Food			
	OTHER:			
Entitled to FSM	YES or NO			
Meal Arrangement	Packed lunch ☐		School Meal ☐	

Emergency Consent

In the event of the school, not being able to contact you, do we have permission to take your child to hospital?

Please tick	YES		NO		
Medical Practice:	Address:				Telephone Number:

Medical Allergies

Please provide details of any medical allergies your child has.

Hayfever		Amoxicillin	
Excema		Penicillin	
Latex		Erythromycin	
Psoriasis		OTHER: Medical allergies	

Does your child require any medication to be taken in school? If **YES** please complete the REQUEST FOR SCHOOL TO ADMINISTER MEDICATION PARENT CONSENT FORM(S) and return to school with this form.	Yes or No
Does your child require any medication to be taken at home? If **YES** please complete the LIST OF MEDICATION GIVEN AT HOME FORM and return to school with this form, so that we are aware what medication is being taken outside of school.	Yes or No

Medical Condition(s)

Epilepsy

Does your child have Epilepsy? (please circle)	Yes or No If yes please complete below
Does your child have an Epilepsy Care Plan?	Yes or No
Does your child need emergency rescue medication?	Yes or No

Medication	Dose	When to be taken

Diabetes

Does your child have Diabetes? (please circle)		Yes or No If yes please complete below
Does your child have an Diabetes Care Plan		Yes or No
Does your child need emergency rescue medication?		Yes or No
Medication	Dose	When to be taken

Asthma

Does your child have Asthma? (please circle)	Yes or No
Does your child need help taking their inhaler?	Yes or No

If yes please complete the attached Asthma form and return it with this pack

Any other medical conditions

Does your child wear glasses?			Yes or No
Does your child wear hearing aids?			Yes or No
Does your child use a wheelchair in school?	If yes please tick below		Yes or No
Manual	☐		
Electric	☐		
Does your child have other mobility issues? **If yes please explain below.**			Yes or No

Ethnicity:		**Religion:**	
Country of Birth:		**First Language:**	
Nationality:			

Consent requests	
Do you give consent for the following until your son/daughter leaves school	**Yes or No**
For local walks eg local shops	
To travel on the school mini buses within the Rochdale Borough Area	
To travel with staff on public transport and in staff cars	
To apply suntan lotion	
Body hygiene eg showering & applying deodorant	
Various Food tasting	
Hand/arm/foot/shoulder massage including massage oil	
Henna body art	
Nail cutting	

Face Painting	
Foot Spa	
Access to animals eg dogs	
To use beauty products eg make up, nail varnish, moisturisers & cleansers **If there are any products you don't want us to use please state below:**	

Signature of parent/carer: ……. **Date:** …….

Trampolining and Rebound

Trampolining and Rebound are part of our Physical Development curriculum.

- Are there any medical reasons that would prevent your child from accessing a trampoline?

No ☐ Yes ☐ **If yes please state below** :

- **If your child has Downs Syndrome, an additional screening form will need to be completed by your GP**.

If a form is required please tick the box ☐ and we will send one home with your child.

Signature of parent/carer: ……. **Date**: ……..

Educational Visits During School Time

There will often be occasions when classes or groups of children are taken off school premises by school staff to a variety of places or events to support their work or develop their experiences. If a visit involves leaving the local area, you will receive a letter, informing you of the off-site activity, often with a request for a voluntary contribution towards the cost. Permission is given by signing the declaration below and is valid until the child leaves the school.

Signature of parent/carer: …….. **Date:** ……

Photographs and Video Filming

Throughout the year, it would be beneficial for school to take video clips and/or photographs of educational activities involving your child, for use on displays, on children's records or simply to record the work of the school. We ask that parents/carers consider signing below giving permission for teachers to do this.

We also occasionally invite local newspapers in to take photographs of the children following charitable, sporting or other significant activities. Please consider also signing for this to happen.

Thirdly, we may also take photographs of children engaged in group activities that we later transfer to the school website and/or social media pages.

Permission is given by signing the declaration below and is valid until the child leaves the school.

Without your signature, your child will NOT be included in any of these things.

- * Internal photos/videos _____
- * Newspapers/press _____
- * School website/social media _____

***(Please sign in these three places)**

The data being collected, controlled and processed is in line with General Data Protection Regulations (GDPR). The school has a duty to protect this data and to keep it up to date. The school is required to share some of the data with the Education Authority and with the Department of Education.

Parent/Carer Name: **Signature:** **Date:**

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION
PARENT CONSENT FORM (1)
September 2020

PUPIL'S SURNAME:	
PUPIL'S FORNAME:	
ADDRESS:	
DATE OF BIRTH:	
NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

Parent/Carer signature:	
Date:	

Head teacher's agreement to the administration of Prescribed Medication by Relevant Members of Staff

I agree that the school will administer medication as supplied by the parent/ guardian/carer of:

Pupil's name:	

Signature:	
Date	

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION
PARENT CONSENT FORM (2)
September 2020/2021

PUPIL'S SURNAME:	
PUPIL'S FORNAME:	
ADDRESS:	
DATE OF BIRTH:	
NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

Parent/Carer signature:	
Date:	

Head teacher's agreement to the administration of Prescribed Medication by Relevant Members of Staff

I agree that the school will administer medication as supplied by the parent/ guardian/carer of:

Pupil's name:	

Signature:	
Date	

LIST OF MEDICATION GIVEN AT HOME FORM
September 2020/2021

PUPIL'S SURNAME:	
PUPIL'S FORNAME:	
ADDRESS:	
DATE OF BIRTH:	
NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

NAME OF MEDICATION:	

Full directions for use:

Dosage and Method:	
Timing:	

Parent/Carer signature:	
Date:	

Asthma Care Plan September 2020/2021 Date: ……..

Name		
DOB		
Address		
School		**Class/ Group**
Parent/ Carer name		**GP**
Telephone	**Home**	**Surgery**
	Work	**Telephone**
	Mobile	

Does your child tell somebody when s/he needs there inhaler? **Yes / No**

Does your child need help taking their inhaler? **Yes / No**

Does your child need to take their inhaler before exercise or play? **Yes / No / Occasionally**

Medication:	**Dose**	**When to be taken**

My child's asthma is triggered by: (please tick the appropriate boxes of your child's triggers)

Cold air		**Colds / viral infections**		**Pollen**		**Excitement**	
Changes in weather		**Exercise**		**Dust**		**Emotion**	
Damp / mould		**Night**		**Pets**		**Cigarette smoke**	
Other:							

Relief treatment when needed:

For cough, wheeze breathlessness or sudden chest tightness, give or allow the child to take the inhaler below. After a few minutes the child should feel better & be able to return to normal activities

Medication	**Dose**	**When to be taken**
Expiry dates checked	**Date**	**Sign**

The child/young person should not be left unsupervised while experiencing an asthma attack
IN AN EMERGENCY

An emergency is if any of the following happen:

1. **The asthma attack guideline has been followed and the reliever (blue) inhaler hasn't helped after 2 puffs and then a following 5 puffs.**
2. **Symptoms of cough, wheeze, breathlessness or tight chest get worse or do not improve.**
3. **The child is too breathless to speak.**
4. **The child is becoming tired or exhausted**
5. **There is any doubt about the child's condition**

WHAT TO DO IF THE RELIEVER INHALER HAS NO EFFECT AFTER A FURTHER 5-10 MINUTES

- **Call an ambulance**
- **Continue to give the reliever inhaler 1 puff every minute until the ambulance arrives**
- **Inform the child's parents.**

Childs Name_____

Parental agreement:

I agree that the information in this plan is correct at the time of writing and give my consent for the school/setting staff to administer my child's inhaler in accordance with the school/setting asthma guidelines.
I will provide the school / setting with a reliever inhaler within the expiry date and where necessary, a spacer. I will inform school immediately in writing of any changes in dosage or frequency of the inhaler or if it is stopped.

Parent/Carers Name: ……... **Print Name: ……**

Headteacher agreement:

It is agreed that school staff will administer the child's inhaler in accordance with the agreed asthma health care plan and in line with the school setting/asthma guidelines.

Parents will be informed it their child has required their inhaler that day.

Headteacher Signature: ……..…… **Print Name: ……..……**

Date: …….

Annual Review Date: ……